STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from August 23, 2010 through September 1, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was one hundred and three (103) residents. The survey sample totaled twenty-seven (27) residents.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F225 October 14, 2010 1. Resident R150 no longer resides in the center. The center did not receive an allegation of mistreatment for this resident. 2. Incidents and accidents are reviewed daily during morning managers meeting to determine that investigations were initiated, completed, and reported in accordance to State and Federal laws. 3. The leadership team will be informed by the administrator on or before October 1, 2010 on their responsibility and the process of reporting and investigating alleged abuse, neglect, mistreatment, and/or injuries of unknown sources. Random incident audits of 5% will be conducted by the DON/NHA over the next 45 days to review documentation to determine that proper and timely procedures are followed. 4. The DON will report to the QA committee monthly. The QA committee will analyze the data to determine the need for further recommendations and follow-up to enhance and improve outcomes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathleen A. Duca TITLE Administrator (X6) DATE 9/08/10

Kathleen A. Duca, Administrator 9/14/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to thoroughly investigate an allegation of mistreatment for one (R150) out of 27 sampled residents who sustained a left shoulder fracture. In addition, the facility failed to immediately report this to the officials in accordance with State law through established procedures. Findings include: R150 was originally admitted to the facility on 9/3/09 with diagnoses including hypoglycemia, chronic Clostridium Difficile enterocolitis, diabetes mellitus type II, glaucoma, end stage renal disease and on hemodialysis. R150 was coded on the Minimum Data Set (MDS) assessment dated 9/25/09 for " cognitive skills for daily decision making" as "moderately impaired--decisions poor; cues/supervision required " , required extensive assistance of one staff for transfer, and did not have any accident within the past 180 days. A review of facility Accident/Incident Report dated	F 225		

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F 225	Continued From page 2	F 225		

11/22/09 timed 2:45 AM revealed that R150 was found lying on the floor by the bed by the assigned certified nursing assistant (E7). The incident report documented that R150 apparently was transferring from the bed to a "sitting up" position when this fall occurred. R150 complained of left shoulder pain, however, no increase in pain prior to the fall (R150 with history of left shoulder pain). Range of motion of arm (shoulder and elbow) was documented as " unchanged. "

Review of the facility's policy titled "Accidents and Incidents: Report, Investigation, Follow-up, and Final Disposition " which stated "Any reported or suspected violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation will be thoroughly and timely investigated, " including interviews with the resident, staff members, and any witnesses to the incident.

On 11/23/09, R150 was evaluated by the therapy department and R150 was noted to have declined in physical functioning for transfer with increased pain of left shoulder addition. Orthopedic consultation was recommended.

Review of the 11/24/09 "Report of Consultation" by an orthopedic provider noted R150 with a two week history of left shoulder pain with no history of trauma that R150 can remember. The report noted a diagnosis of left greater tuberosity fracture of left arm with underlying chronic rotator cuff tear.

An interview with E1 (Administrator) on 8/31/10 at approximately 10 AM revealed after the fracture was confirmed on 11/24/09, she related the

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F 225	Continued From page 3 fracture directly to the fall on 11/22/09, thus, did not investigate this allegation of mistreatment or report this to the State Agency. Although R150's fracture was confirmed two days after the fall on 11/22/09, the facility failed to thoroughly investigate this allegation of mistreatment and failed to immediately report this to the State Agency. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 8/30/10 at approximately 1:45 PM.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that one (R49) out of 27 sampled residents did not have a call bell placed within reach to call for assistance. Findings include: On 8/26/10 at 11:46 AM, R49 was noted to have her call bell clipped to the right side of her pillow. The resident was asked to reach and ring the call bell. The resident was unable to reach the call bell because it was clipped out of her reach. The call bell was relocated for the resident so she	F 246	F246 October 14, 2010 1. Resident R49's call bell has been relocated so she can reach and use it. 2. Random rounds have been accomplished to identify any other residents identified as having issues with call bells not in reach. 3. Nursing staff has been informed of the importance of having call bells located where residents can use them. Random unit rounds will be performed weekly over the next 45 days to determine compliance. 4. This will be the responsibility of the DON/ADON/Unit Managers. The DON will report monthly to the QA committee. The Committee will determine the need for further recommendations.	

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F 246	Continued From page 4 could use it. The resident's care plan for being at risk for falls included the approach "keep frequently used items within reach. (call light, i.e.)".	F 246		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that some resident areas were maintained below 71 degrees Fahrenheit (F). Findings include: 1. On 8/24/10 at 11:30 AM several residents were observed wrapped in heavy sweaters or blankets in the activity room and the main dining room. Residents were verbalizing that it was cold. The following temperature readings were obtained; activity room 68.1 degrees Fahrenheit (F), south dayroom 69.3 F, main dining room 68.1 F, and lobby 67.8 F. E6 (Maintenance Director) was made aware of these temperature readings below 71 degrees and residents' complaints of being cold. 2. On 8/30/10 at 12:11 PM, a follow-up temperature was taken at the South Unit nurses station and found to be 68.7F	F 257	F257 October 14, 2010 1. Building temperatures are currently maintained at the range of 71 - 81° 2. Current residents have not indicated that uncomfortable or unsafe temperature levels in the building. 3. Random temperature audits will be performed by Maintenance Director the over the next 45 days to validate temperatures within acceptable ranges. 4. This will be the responsibility of the maintenance team who will report findingsto the administrator.	

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F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide nutritional interventions for one (R205) out of 27 sampled residents in accordance with assessed needs and per physician orders. The facility failed to transcribe onto the Medication Administration record and failed to administer Med Plus (nutritional supplement) twice a day for the month of 8/10 for R205. Findings include: R205 was admitted to the facility on 7/13/10. R205 was started on a fortified food program and House supplement 2.0 (nutritional supplement) 4 ounces daily as per the facility dietitian's recommendations on 7/13/10. R205 was readmitted to the facility on 7/28/10 after a hospitalization. On 7/29/10, the facility dietitian recommended Med Plus 2.0 4 ounces twice a day to supplement her oral food intake, which the MD ordered the same day. The order for Med Plus was appropriately transcribed onto	F 325	F325 October 14, 2010 1. Resident R205's MAR was corrected and the resident receives the currently prescribed supplement. 2. An audit was performed on residents receiving nutritional supplements and no other residents were identified as not receiving supplements as ordered. 3. Random MAR audits of not less than 5% will be performed over the next 45 days to validate accuracy on MAR transcriptions 4. This will be the responsibility of the DON/Nurse Managers, who will report monthly to the QA committee. The Committee will determine the need for further recommendations.	

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F 325	Continued From page 6 the 7/10 MAR (Medication Administration Record) and administered as ordered. Review of the 8/10 MAR, however, revealed that the nutritional supplement order was not transcribed. The 9/10 MAR had the order handwritten and on 9/1/10 the AM dose was signed out as given. During an interview with E11 (unit manager) on 9/1/10, she confirmed that the order for Med Plus was not transcribed onto R205's 8/10 MAR. During a telephone interview with E12 (LPN), R205's usual 3-11 shift nurse, he stated that he was unable to recall giving Med Plus recently to R205, but he only gives what is written on the MAR. The facility failed to transcribe and provide R205's nutritional supplement as ordered for the month of 8/10.	F 325	F329 October 14, 2010 1. Resident R150 no longer resides in the center. 2. An audit will be performed by the consultant pharmacist over the next 45 days to identify other residents whose recommendations have not been addressed for further follow up. 3. Recommendations from the pharmacist are submitted monthly and will be put on the residents chart to alert staff for follow up. 4. This will be the responsibility of the DON/Nurse Managers, who will report monthly to the QA committee. The Committee will determine the need for further recommendations.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 7 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R150) out of 27 sampled residents' drug regimen was free from unnecessary drugs. The facility failed to monitor laboratory values for R150. Findings include: Review of R150's medication regimen revealed the resident was receiving Pravachol (antilipemic agent) 80 mg. (milligram) daily since readmission to the facility on 9/3/09. The clinical record lacked evidence of a recent blood lipid panel. Review of the monthly "Medication Regimen Review" (MRR) noted on 1/5/10, the consultant pharmacist noted an irregularity while reviewing R150's medication regime. During the survey, E2 (DON) was repeatedly asked to provide a copy of the irregularity report, however, no report was provided. An interview with the E10 (consultant pharmacist) on 9/1/10 at approximately 1:55 PM revealed that during the January 2010 MRR, it was identified that R150 required a blood lipid panel to monitor the effectiveness of the Pravacol, thus, recommendation was made to obtain this blood work. During the April 2010 MRR review, E10 once again requested for the lipid panel to be	F 329		

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F 329	Continued From page 8 done. The facility failed to monitor the effectiveness of and the potential for adverse consequences of the Pravachol that R150 was receiving. Findings reviewed with E1 (Administrator) and E2 (DON) on 9/1/10 at approximately 1 PM.	F 329		
F 388 SS=D	483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R49, R81, and R110) out of 27 sampled residents the facility failed to ensure that the physician conducted every other required visit. Findings include: 1. R49's clinical record had documented recertification visits from the nurse practitioner on 11/23/09, 1/20/10, 2/18/10, 3/17/10 and 5/17/10. The physician documented a visit on 7/19/10. An interview with the unit manager E5 on 9/1/10 confirmed there were no other documented recertification visits from the physician. She	F 388	F388 October 14, 2010 1. Resident R49, R81, and R110's has been currently seen by the physician. 2. An audit will be performed by the medical records personnel in conjunction with the physician group to identify other residents who are in need of a physician visit. Physician's will complete the required visit in the next 30 days. 3. Physician's will keep a monthly record of alternating visits of all residents. Medical records will perform monthly audits to assist with identifying those who require physician visits. 4. This will be the responsibility of the Medical records personnel who will report to the DON monthly. The DON will report monthly to the QA committee. The Committee will determine the need for further recommendations.	

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F 388	Continued From page 9 further stated that there was a recent change in the primary physician attending at the facility. 2. R81's clinical record had documented recertification visits from the nurse practitioner on 11/16/09, 1/3/10, 3/10/10, 5/10/10. and 7/12/10 The physician documented an acute visit on 6/19/10. An interview with the unit manager E5 on 9/1/10 confirmed there were no other documented recertification visits from the physician. She further stated that there was a recent change in the primary physician attending at the facility. 3. R110's clinical record had documented visits from the Nurse Practitioner (NP) on 4/12, 4/28, 5/27, 6/7, 6/21, 6/28, 7/1, 7/19, 7/22 and 7/28/10. The physician performed an admission history and physical examination on 3/31/10 and the only other physician progress note was dated 7/8/10. While the physician did the initial visit, the NP did both the 30 day and 60 day visits. E8 (LPN) confirmed on 8/26/10 there were no other documented physician visits.	F 388		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 10 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation in the north unit hallway on 8/2310 and on 8/30/10, it was determined that the facility failed to handle and transport linen to prevent the spread of infection. Findings include: E4 (certified nursing assistant) was observed to be collecting soiled laundry from the rooms on the 300 hallway. This staff member was entering rooms, collecting the soiled personal laundry, placing it in or on the soiled linen cart in the hallway, then progressing to the next room	F 441	F441 October 14, 2010 1. The certified nursing assistant has been informed and is currently being randomly monitored for compliance of safe linen handling. 2. No other observations were identified for failure to follow an infection control program. Random rounds will be performed over the next 45 days to observe safe linen handling. 3. An in-service will be performed on or before September 30, 2010 to review Infection Control practices and policies on safe linen handling and transport of linen for the certified nursing assistants. 4. This will be the responsibility of the Infection Control Nurse who will report to the DON monthly. The DON will report monthly to the QA committee. The Committee will determine the need for further recommendations.	

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F 441	Continued From page 11 without changing the protective, disposable gloves. Door handles, cart handles, and common surfaces were being touched with contaminated gloves. Three rooms were observed to be contaminated by this process.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085039	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/1/2010

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview it was determined that the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessment for one (R150) out of 27 sampled residents. Findings include:

Review of R150's quarterly MDS dated 3/7/10 noted presence of one, stage II pressure ulcer (PU). Review of the "Skin Grid" documentation initiated on 1/6/10 noted presence of one PU of the sacrum with 1 cm. (centimeter) in length by 1 cm. in width and 0.1 cm. in depth. This PU was documented to have healed on 1/14/10. On 2/10/10, this PU re-opened and was staged as a stage II and was documented as healed on 2/24/10.

An interview on 8/31/10 at approximately 2:25 PM with E9 (Licensed Practical Nurse) who coded the above 3/7/10 MDS assessment confirmed that this was an error in coding since the pressure ulcer healed on 2/24/10.

Kathleen H. Ducy Administrator 9/13/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: 9/1/10

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey and complaint visit was conducted at this facility from August 23, 2010 through September 1, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was one hundred and three (103) residents. The survey sample totaled twenty-seven (27) residents	Cross Reference to CMS 2567 survey report date completed September 1, 2010, F278, F225, F246, F257, F325, F329, F388, F441, with a Plan of Correction Date of October 14, 2010
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey	

Provider's Signature Kathleen H Duncan Title Administrator Date 9/28/10

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	report date completed 9/1/10, F225, F246, F257, F278, F325, F329, F388, F441.	